METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/97 OTHER PRACTITIONER SERVICES

Advanced Registered Nurse Practitioner, Nurse Midwife, Licensed Midwife, Physician Assistant and Registered Nurse First Assistant Services: Individual payments are based on a fee schedule determined by the state agency and will not exceed the upper limits established through application of the parameters at 42 CFR 447.304.

Amendment 97-08
Effective 7/1/97
Supersedes 93-02

Approval 8/25/97

FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION VII

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than 3 calendar months after the close of its cost reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual (HCFA PUB. 15-1 as incorporated by reference in

Rule 59G-6.010, Florida Administrative Code (F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs (including outpatient fixed costs); or the budgeted rate in compliance with HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. and Section III of the Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

D. The cost report shall be prepared in accordance with the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35-413.50 (1995), and further interpreted by the Provider Reimbursement Manual (HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.) except as modified by this plan.

E. Hospitals shall file a legible and complete cost report within 3 months, or 4 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.

F. A hospital which does not file a legible and complete cost report within 6 calendar months after the close of its reporting period shall have their provider agreement, that is, contract, canceled.

G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when: the capital stock of a corporation is sold; or partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

H. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c)(1995). For purposes of this

plan, statistical records shall include the medical records of eligible Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent such as the Medicaid consent form, AHCA-Med Form 1005 as incorporated by reference in Rule 59G-1.002 (13), F.A.C.

I. Records of related organizations as defined by 42 CFR 413.17 (1995) shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

J. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60 (1995). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the party making the request and the information requested. Unless prohibited by a court of competent jurisdiction,

the cost report shall be released to the requestor 15 days from receipt of the request by AHCA.

II. Audits

A. Background

A hospital common audit program has been established to reduce the cost of auditing submitted cost reports and avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital which shall serve the needs of all governmental programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII, and XIX. Under this agreement, the intermediaries shall provide AHCA the result of desk reviews and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits. AHCA shall:

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;

3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 (10/94) F.A.C.

4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.160 F.A.C..

5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required.

6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 (10/94), F.A.C. and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60 (1995).

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audits using prior

approved State plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.

2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely, overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.

4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.

5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.

6. The terms of repayments shall be in accordance with Section 409.335, Florida Statutes.

7. All overpayments shall be reported by AHCA to HHS as required.

8. Information intentionally misrepresented by a hospital in the cost report shall result in a

suspension of the outpatient hospital from the Florida Medicaid Program.

F. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Rule 59-1.018(4), F.A.C., and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs shall be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.35-413.50 (1995), the inpatient routine nursing salary cost differential, and the guidelines in the Provider Reimbursement Manual (HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. except as modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 (1995)and 42 CFR 440.140 (1995) in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;

2. The requirements established by the State Agency responsible for establishing and maintaining

health standards under the authority of 42 CFR 431.610 (1995); and

3. Any other requirements for licensing under the State law which are necessary for providing inpatient hospital services.

B. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321 (1995).

C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Outpatient costs to Total Hospital Costs.

D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to